

**CRITERIA FOR PRIOR AUTHORIZATION**

**Repository Corticotropin Injection**

**PROVIDER GROUP** Pharmacy  
Professional

**MANUAL GUIDELINES** The following drug requires prior authorization:  
Repository Corticotropin Injection (H.P. Acthar Gel®)

**CRITERIA FOR INFANTILE SPASMS:** (must meet all of the following)

- Patient has a diagnosis of infantile spasms
- Prescribed by or in consultation with a neurologist
- Patient is  $\leq 2$  years of age

**CRITERIA FOR MULTIPLE SCLEROSIS:** (must meet all of the following)

- Patient has a diagnosis of multiple sclerosis
- Prescribed by or in consultation with a neurologist

**CRITERIA FOR RHEUMATIC DISORDERS:** (must meet all of the following)

- Patient has one of the following diagnoses:
  - psoriatic arthritis
  - rheumatoid arthritis
  - juvenile rheumatoid arthritis
  - ankylosing spondylitis
- Prescribed by or in consultation with a rheumatologist

**CRITERIA FOR COLLAGEN DISEASES:** (must meet all of the following)

- Patient has one of the following diagnoses:
  - systemic lupus erythematosus
  - systemic dermatomyositis (polymyositis)
- Prescribed by or in consultation with a rheumatologist

**CRITERIA FOR DERMATOLOGIC DISORDERS:** (must meet all of the following)

- Patient has one of the following diagnoses:
  - erythema multiforme
  - Stevens-Johnson syndrome
- Prescribed by or in consultation with a dermatologist

**CRITERIA FOR ALLERGIC STATES:** (must meet all of the following)

- Patient has a diagnosis of serum sickness
- Prescribed by or in consultation with an allergist or immunologist

**CRITERIA FOR OPHTHALMIC DISEASES:** (must meet all of the following)

- Patient has one of the following diagnoses:
  - keratosis
  - iritis
  - iridocyclitis
  - diffuse posterior uveitis and choroiditis
  - optic neuritis
  - chorioretinitis
  - anterior segment inflammation
- Prescribed by or in consultation with an optometrist or ophthalmologist

**CRITERIA FOR RESPIRATORY DISEASES:** (must meet all of the following)

- Patient has a diagnosis of sarcoidosis
- Prescribed by or in consultation with a pulmonologist

**CRITERIA FOR EDEMATOUS STATE:** (must meet all of the following)

- Patient has proteinuria in the nephritic syndrome without uremia of the idiopathic type or that due to lupus erythematosus
- Prescribed by or in consultation with a rheumatologist or nephrologist

**LENGTH OF APPROVAL**      12 months